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ABSTRACT

A family planning clinic which was part of a large public maternity hospital in Salvador Bahia, Brazil received a grant to expand its services and to evaluate a service model focusing on client counseling and education. The counseling, education, and service provision process included individual pre-consultation with a nurse, group education and discussion, a medical examination/consultation, and a post-consultation interview. The family planning service program experienced political problems because family planning research programs, which depended on maintaining a certain client load, were losing potential clients to the clinic. As a result, the service program was forced to stop admitting clients and thus the program could only be evaluated for a 3-month period. The impact of counseling and education through increases in knowledge and user satisfaction was investigated by administration of an open-ended questionnaire to 115 new and follow-up patients. Findings indicated that: (1) users were satisfied with the service; (2) group education was more cost efficient than individual counseling; (3) the patient flow model was inefficient; (4) the length of the process was inconvenient for clients; (5) sexuality education was welcomed; (6) intrauterine devices were favored by 60% of clients with only 5% choosing oral contraceptives; and (7) only 10 unplanned pregnancies occurred among 1,776 clients during the 18-month project. Apparently the linkage of information on sexuality and use of family planning methods led to the program's popularity. (ABL)

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Talk Given by Bonnie Shepard at the American Public Health Association Meeting, September 30, 1986

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A HOLISTIC APPROACH TO FAMILY PLANNING COUNSELING AND EDUCATION

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Introduction

In November of 1983, a family planning clinic was established at a large public maternity hospital, Maternidade Climerio de Oliveira, in Salvador, Bahia, Brazil. The Pathfinder Fund awarded a grant to the clinic in July 1984 to expand its services, and to evaluate a service model that focused on client counseling and education. This paper will describe the service model, the project history, and the evaluation results.

The Family Planning Service Model at Maternidade Climerio de Oliveira

The family planning clinic was run by nurses, and operated in the research division of this large public maternity hospital. It was open to clients three days a week from 7 a.m. to 3 p.m. and operated with a sliding fee scale. Although the hospital is located in a middle-class neighborhood, almost all of its clients are low-income and travel from neighborhoods throughout the city of Salvador. The project offered all temporary contraceptive methods except the vaginal suppository, and referred clients for that method and for voluntary sterilization. The service was staffed by two nurses (one of whom was the Project Director), a female doctor, a social worker and a nurse's aide.

The service was designed with strong and comprehensive counseling and education that offered information and opportunities for clients to raise questions and discuss topics relating to human reproduction, contraceptive methods, and sexuality. This component was carried out in a warm and caring manner designed to put women at ease and encourage them to participate. The counseling, education, and service provision were divided into four stages: 1) individual pre-consultation with a nurse; 2) group education and discussion; 3) medical exam/consultation; and 4) post-consultation interview.

This service model required a considerable time commitment on the part of new clients. In spite of this inconvenience, the service was noticeably sought after, and the majority of women were referred by word of mouth from satisfied clients. The number of new family planning clients varied from 10 to 15 on most days; they were seen in the morning, typically arriving

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between 7 and 8 a.m. During the pre-consultation interview, one of two nurses took a medical history, discussing any outstanding health problems. The client was also asked about contraceptive use and needs, about her sexual life, and then was encouraged to discuss these topics in more depth. Each day, all new patients participated in the first interview before the group session took place, usually between 9:45 and 10:00 a.m. The group session was given by the nurse or the nurse's aide, typically took an hour, and covered reproductive physiology, contraceptive methods, and sexuality. The evaluator comments that although by this time many of the women were tired and hungry, having gotten up at 4:30 or 5 in order to make it to the clinic, they were visibly eager to receive the information in the class, and participated actively by asking questions and joining in group discussions. Observers noted that the educator went to great pains to encourage this participation, trying to reduce social distance by emphasizing that "we're all women here, and we all have the same problems." The majority of the questions and discussions centered around the topics of the IUD, and sexuality. The medical exam followed, by which time around 90% of the clients knew which method they wanted to use. The doctor screened them for contraindications, and provided those who wanted o.c.'s and IUD's with temporary methods if they were not menstruating at the time. The post-consultation interview was conducted by the nurse's aide, who asked them about any remaining doubts or questions, gave the client an instruction sheet on the method chosen, and made an appointment for follow-up. She encouraged them to come back sooner if there were any problems. This whole process took 4-5 hours, so that patients who arrived between 7 and 8 a.m. usually left between 12 and 12:30 p.m.

Returning clients were seen in the afternoon, and went through a much shorter process. In a pre-consultation with the nurse, they were asked about satisfaction with the method, and about progress in their relationship with their partner; this consultation was brief if there were no major problems. They were then seen by the doctor, and given a post-consultation.

During the program, the Project Director recognized that over 50% of her clients were expressing needs for counseling on sexual problems beyond what the program could provide, and was able to set up referrals to a sexologist working in another section of the hospital.

Project History

The family planning service began to experience serious political opposition about six months into the funding period. The problems were caused by its very success in attracting clients. The contraceptive research programs located in the same hospital, that depend on a certain client load for their existence, were losing potential clients because word of mouth brought many of the women who wanted family planning to the project clinic. Those programs were run by doctors, who exercised more power within the Maternity than the project director, who was a nurse. By June, 1985, when the project evaluation was scheduled to begin, the project director had succumbed to internal pressure and promised to stop admitting new patients to her clinic by the end of August. As a result, then, the sample of new users for the evaluation only covered a three-month period. The Pathfinder Fund ended funding in November 1985 because the service was

seeing no new clients, and the service as it existed closed down in March of 1986. This caused much distress to the staff, and to many of the program's clients.

Evaluation Design

The original objective of the evaluation was to study the effect of the intensive counseling and education sessions on continuation rates, effectiveness of method use, and method choice and switching. Given the previously described political problems and limitations on seeing new clients, it was not possible to have a control group, nor was the evaluation able to last long enough to generate meaningful data on continuation rates. The focus of the evaluation was then changed to measure the impact of counseling and education through increases in knowledge and user satisfaction.

An open-ended questionnaire was applied to a sample of 115 new and follow-up patients (representing 8% of the clients) during a three month period. Service statistics were examined for data on method choice and effectiveness of use. The evaluator also relied extensively on qualitative techniques to understand the project history and the effect of the service on the clients.

Evaluation Findings

1. The majority of new acceptors were referred by word of mouth. This was an indicator of user satisfaction. After one year, the service was operating close to maximum capacity, with an average of 12 new clients a day, and had a higher patient load than any of the f.p. research-related services at the hospital (which were in fact losing clients to the project clinic.). This experience suggests that it may not be a good idea to establish client-responsive models in places where there is risk from more politically powerful competition who can't afford to lose clients.

2. The group education model is more cost-effective and feasible with limited staff resources than providing extensive individual counseling time. In this service, the maximum individual counseling time for a woman would have been 15-25 minutes. The group session gave an average of 12 new clients daily 3 to 4 times more education and counseling at the cost of only 1 hour of staff time.

3. The patient flow model used was very inefficient; the 3 to 4 times increase in education and counseling time was achieved at the cost of about 2-3 extra hours spent in the clinic for the new client. Simply by having the group education first thing in the morning, the providers could have reduced the average time new users spent in the clinic by 1 1/2 to 2 hours.

4. As mentioned above, the service model was in many ways inconvenient for users, most of whom were low-income mothers who had to travel a long way on public transportation to get to the hospital. The women were very tired by the time they got to the clinic, and were then faced with a 4-5 hour education, counseling, and examination process. Theoretically, one would suppose that this time commitment would make the service less acceptable to

clients. In fact, the evaluator found that the service was one of the most popular in town in spite of this drawback. The popularity was not decreased by the lengthy education and information sessions, and was enhanced by the welcoming and sympathetic atmosphere provided by the staff. In fact, many of the continuing users asked to attend the group educational session a second time, even though they were not required to do so.

5. Over 50% of the clients came to the educational sessions looking for additional information about the IUD, and also reporting significant problems in their sexual lives. The clients answering the questionnaire found the classes most helpful in informing them about IUD's, sexual relations, and "frigidity". The sexuality education and discussion was provided in a way that demystified the concept of frigidity, allayed the women's feelings of guilt and inadequacy, and pointed to concrete solutions to the problems women voiced. Results from post-session interviews indicate that all respondents increased their knowledge of reproductive physiology after the class. Those returning to the group sessions for a second time were mainly interested in discussing sexuality. The older women showed a greater ignorance of reproductive and sexual topics than the younger women, and thus had a harder time absorbing all of the information presented in the class.

6. Sixty percent of the 1,1776 clients chose to use IUD's. This is a significant difference from a random sample of 7 other services funded by Pathfinder in Brazil, in which the average percentage of IUD use was 18.8%. In those sampled by questionnaire, about 75% of clients under 26 were using oral contraceptives when they came to the clinic. A significant proportion of these women must have switched from oral contraceptives to IUD's, given the small percentage of continuing users of o.c.'s in the program reports. When these findings are added to the findings that a majority of the questions and doubts about methods raised in the educational sessions were about IUD's, and that women stated that the information about IUD's and sexuality had been the most helpful part of the session, a hypothesis emerges that intensive education and counseling of clients increases the acceptance of IUD's, assuming that the provider is comfortable with the method. According to client interviews, other reasons the women chose IUD's were the lack of fees or low fees for low-income women, the IUD being "American", (synonymous in their minds with high quality), and ease of hiding the use of the method from their husbands. (However, these reasons apply to the afore-mentioned Pathfinder projects as well, and therefore do not explain the high acceptance of IUD's in this project).

7. Five percent of the clients chose to use oral contraceptives, and 34% of all clients asked for referrals to the nearby service for sterilizations. The complaints most often voiced about the pill were nervousness, headaches, and breast problems. Just as the high percentage of IUD users and referrals for sterilization were unusual in this project, so was the low percentage of barrier method and pill use. The evaluator did not note any provider bias in her observations, but it is certainly possible that it existed. Another explanation for the low pill use provided by the evaluator, who is an anthropologist, is that most clients came to the clinic for the purpose of getting off the pill, which was readily available in community pharmacies without medical consultation. Her hypothesis is that most of the low-income women attending the clinic were from families

that still held a rural Northeast medical belief system; in this system, all oral medicine is seen as dangerous and is termed "química" or chemicals. While there were many adverse rumors circulating about the IUD's in the women's neighborhoods, as evidenced by the questions asked in the classes, they were still eager to find out about and try a "non-chemical" method. The high usage rate of IUD's suggests that the classes and counseling effectively combatted the rumors about IUD's.

8. With regard to the issue of effectiveness of method use, there were only 10 unplanned pregnancies among 1,776 clients during the 18-month life of the project, most of them due to Lippes Loop method failure. With regard to continuation rates, only 17 of the 1,058 IUD users asked to have the device withdrawn. It seems that barrier methods were only used as temporary methods until women's cycles allowed them to start o.c.'s or IUD's, or until their sterilizations were performed. This unusually low usage of barrier methods (120 of contraceptives distributed) probably contributed to the low pregnancy rate, although at the same time it points to the possibility of provider bias.

Discussion and Conclusion

The evaluation of the experience of this family planning clinic offers several valuable insights for future programs. First of all, it is yet another demonstration of the welcoming, caring and client-responsive atmosphere that often, at least in Pathfinder experience, characterizes services run by nurses.

Secondly, the experience of this clinic demonstrates the value of incorporating group education sessions into family planning services. These supportive and participatory group education sessions effectively combatted rumors about IUD's; this is important because in many cases these rumors are the main barrier to women's use of an effective method. Even more importantly, the findings illustrate the attracting force of linking discussions of family planning with information and discussions of the clients' concerns about their sexual relationships.

What is remarkable about these findings is that not only were clients willing to put up with the exorbitant time commitment demanded by the service model; they positively flocked to the clinic. The opportunity to participate in this type of group session was so compelling that followup clients came back in the mornings a second time, when they could have come back in the afternoon and only spent an hour at the clinic. Why should they do this? Why was this inefficient service model so attractive and popular? The most likely explanation is that the linkage of information on sexuality and use of family planning methods was the decisive attracting factor. This natural linkage, when done in a validating and frank manner, could greatly enhance any family planning service by dealing with those emotional, social, and sexual dynamics that are most intimately linked with the use of contraception.